Dauntless Leaders in Nursing: Impacting Patient Safety

October 18, 2018
Webinar Month 119

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Welcome

Charles Denham, MD

Chairman, TMIT

TMIT High Performer Webinar
October 18, 2018
Webinar 119
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High Performer Webinar

October 18, 2018, 12:00 pm – 1:30 pm CT / 1:00 pm – 2:30 pm ET

Dauntless Leaders in Nursing: Impacting Patient Safety

Session Overview

Kathleen Bartholomew, RN, MN is an accomplished author in patient safety with breakthrough professional books such as “Ending Nurse-to-Nurse Hostility” and “Charting the Course” (co-written with John Nance). From the bedside to the boardroom she challenges health care leaders to protect patients with research based presentations woven with narratives that resonate strongly with her audiences. She will address key issues in her latest book “The Dauntless Nurse: Communication Confidence Builder” and how they may empower us our patient safety mission.

A reactor panel of patient advocates and subject specific experts will react to the presentation.

We offer these online webinars at no cost to our participants.

Webinar Video, and Downloads

The webinar video will be available within five (5) business days after the webinar.

Speaker Slide Set:
If you wish to follow us on Twitter, go to: http://twitter.com/TMIT1 or use #safetyleaders hashtag

Also, go to:
www.facebook.com/SafetyLeaders and related sites
TMIT Purpose Statement

Our Purpose:
We will measure our success by how we protect and enrich the lives of families...patients AND caregivers.

Our Mission:
To accelerate performance solutions that save lives, save money, and create value in the communities we serve and ventures we undertake.
Disclosure Statement

The following panelists certify: that unless otherwise noted below, each presenter provided full disclosure information; does not intend to discuss an unapproved/investigative use of a commercial product/device; and has no significant financial relationship(s) to disclose. If unapproved uses of products are discussed, presenters are expected to disclose this to participants. None of the participants have any relationship medication or device companies discussed in their presentations.

Kathleen Bartholomew held positions in marketing, business, communications, and teaching. It was these experiences that allowed her to look at the culture of healthcare from a unique perspective and speak poignantly to the issues affecting providers and the challenges facing organizations today. She has nothing to disclose.

Becky Martins’ advocacy spirit derives from the days when she was driving a family member 150 miles round-trip, three days a week, to dialysis treatments. She spent countless hours at the unit visiting with patients and their families. It was through their stories that she learned of the many challenges faced by patients living with chronic illness. It was by their example that she learned of the resilience of the human spirit to face health and health-related challenges head-on. The unit was her classroom, and her teachers were the patients and families, along with the unit staff who cared for them. The experience became the impetus for her advocacy on behalf of end-stage renal disease patients. In 1996, Becky was the recipient of the Kidney Foundation of Maine Board of Trustees’ Service Award for 10 years of service. She has nothing to disclose.

Charles Denham, MD, is the Chairman of TMIT; a former TMIT education grantee of CareFusion and AORN with co-production by Discovery Channel for Chasing Zero documentary and Toolbox including models; and an education grantee of GE with co-production by Discovery Channel for Surfing the Healthcare Tsunami documentary and Toolbox, including models. HCC is a former contractor for GE and CareFusion, and a former contractor with Siemens and Nanosonics, which produces a sterilization device, Trophon. HCC is a former contractor with Senior Care Centers. HCC is a former contractor for ByoPlanet, a producer of sanitation devices for multiple industries. He does not currently work with any pharmaceutical or device company. His current area of research is in threat management to institutions and continuing professional education and consumer education including bystander care. Dr. Denham is a collaborator with Professor Christensen.
Speakers and Reactors

Kathleen Bartholomew

Becky Martins

Charles Denham
Voice of Patient and Family

Becky Martins

Founder, Voice4Patients.com
TMIT Patient Advocate Team Member
Warren, ME

TMIT High Performer Webinar
October 18, 2018
In the News Update and September 2018 Webinar National Survey

Charles Denham, MD

Chairman, TMIT

TMIT High Performer Webinar
October 18, 2018
Webinar 119
In The News …

Snapping the perfect selfie can be fun. But if it involves flying a plane or holding a loaded handgun or standing on slippery rocks near the top of a waterfall, you may want to think twice.

Some 259 people worldwide have died while taking selfies, according to a study published in the Journal of Family Medicine and Primary Care. Researchers from the All India Institute of Medical Sciences, a group of public medical colleges in New Delhi, scoured news reports on selfie deaths that occurred from October 2011 to November 2017.

They found that the most selfie deaths occurred in India, followed by Russia, the US and Pakistan. Most of the victims were men (about 72%) and under the age of 30.

India accounted for more than half the total -- 159 reported selfie deaths since 2011. Researchers attributed the high number to the country’s enormous population of people under 30, which is the world’s largest.

- Drowning is the leading cause of selfie deaths, usually involving people being washed away by waves on beaches or falling out of a boat.
- The second-leading cause is listed as "transport" -- people killed, for example, while trying to snap a quick pic in front of a moving train.
- Tied for third are selfie deaths involving fires and falls from high places. Eight people died while taking selfies with dangerous animals.
- Unsurprisingly, the US led in the number of selfie deaths involving a firearm -- people accidentally shooting themselves while posing with guns.

Selfie deaths are on the rise, too. There were just three reported selfie deaths in 2011. By 2016 that number had shot up to 98.

The study's authors suggest that "no selfie zones" be established in tourist areas, especially on mountain peaks, near bodies of water and on top of tall buildings. India has more than a dozen of these zones, including several in Mumbai.
A Medical-Tactical Approach undertaken by clinical and non-clinical people can have enormous impact on loss of life and harm from very common hazards:

- **High Impact Care Hazards** are frequent, severe, preventable, and measurable.
- **Lifeline Behaviors** undertaken by anyone can save lives.
Meaningful Use is dead. Long live something better!

YouTube Patient Safety Briefings

Opioid Overdose Crisis
https://www.youtube.com/watch?v=p4OiKAshEUE&feature=youtu.be

Sudden Cardiac Arrest
https://www.youtube.com/watch?v=qdXW5WxDY8&feature=youtu.be

Active Shooter Events in Healthcare
https://www.youtube.com/watch?v=qSsWAs5JJBw&feature=youtu.be

2018 YouTube Patient Safety Briefings

Med Tac Bystander Care Training
https://www.youtube.com/watch?v=2IM0jh4qCQU&feature=youtu.be

Med Tac Lifeguard-Surf Program
https://www.youtube.com/watch?v=G1V8s7LWL6M&feature=youtu.be

Sudden Cardiac Arrest
More than 40 out of hospital sudden cardiac arrests every hour.
90% ARE FATAL.
Dylan Thomas, the 16-year-old linebacker, fought off blockers twice his size. He tackled ball-carriers to the turf. And then he got back up and did it again.

He died on Sunday from a head injury that first showed its impact in the third quarter, when he came off the field and said his leg was feeling weird, coach Brad Webber said. He later became incoherent and lost consciousness on the sideline.

The footage does not clearly show any traumatic or catastrophic hits to his head. At one point in the second quarter, he is seen in the video being hit by two players on a running play and is slow to get up afterward. He gets up after that and continues playing.

But in the third quarter, the camera cuts to the sideline, where Dylan is being carried on a stretcher toward an ambulance that had driven onto the field. The crowd claps supportively, unaware of the devastation to come.

Shirley Reeves, the chairwoman of the Child Fatality Review Committee for Upson & Pike County, said all child fatalities in Georgia are reviewed by a board when the death is sudden, unexpected or unexplained.

Game-related deaths of football players are rare, but they happen every fall. Last year, of the 4 million young people who played organized football, 13 died from the sport, according to the National Center for Catastrophic Sport Injury Research.

Four of the deaths had "direct" causes from on-field trauma or injuries, and nine deaths were due to "indirect" causes such as heat stroke or cardiac arrest. The 2017 death toll was consistent with football-related fatalities dating back to 2000.

High School Football Player Died of Cardiac Arrest Stemming from Head Injury, Coroner Says

He died at the Atlanta hospital on September 30, after at least 40 hours of surgery, medical testing and additional life-saving measures, the coroner said in a statement.

He was in "great physical shape," and there were no pre-existing medical conditions detected, the statement said.

Without an autopsy, there is no way to know whether Dylan had an unidentified pre-existing condition.

Doctors "described to Dylan's parents the nature of the injury as an anomaly, requiring the perfect amount of pressure on the perfect spot at the perfect angle," according to the statement.

The Georgia High School Association, the organization that oversees Georgia high school sports, said there "is no indication of any negligent action by anyone associated with Pike County in this incident."

"The coaches had taken every precaution to prepare for potential injuries and went beyond the required standards when working within the concussion protocol," the organization said.

A 13-year-old boy who was attacked by a shark early Saturday is in serious condition, downgraded from the critical condition he was in originally, according to a spokesperson from Rady Children's Hospital in San Diego.

The boy was attacked while diving for lobsters in waters off Encinitas, California, near San Diego, authorities said.

The boy suffered traumatic injuries to his upper torso and was taken to a hospital, Encinitas lifeguard Capt. Larry Giles told reporters. Encinitas is about 25 miles north of San Diego.

Several people were in the water diving for lobsters, he said, because it was the opening of the season for catching the crustaceans. Three good Samaritans heard the boy's cries and helped bring him ashore using a kayak, Giles said.

Lifeguards had been on duty early Saturday because of two nearby events, and the response to the attack was "very short," Giles said.

"The lifeguard was within a quarter-mile of the incident with a lifeguard truck and arrived on scene and started providing first aid right away," he said. The lifeguard was an emergency medical technician, Giles added.

Paramedics arrived soon after, and the boy was taken to the hospital. He was conscious and talking on the beach, Giles said, as well as on his way to the hospital.

In The News …

British Prime Minister Theresa May has appointed what is thought to be the world's first minister for suicide prevention.

The move, intended to tackle the tragedy of 4,500 people taking their own lives in England each year, comes on World Mental Health Day.

Jackie Doyle-Price, a Conservative MP and current health minister, has been appointed to lead the government's efforts to confront the issue, which is the leading cause of death in men aged under 45.

The new role will head up a ministerial taskforce, working with experts in suicide and self-harm prevention, charities, clinicians and those personally affected by suicide.

Suicide is the second leading cause of death globally for young people aged between 15 and 19.

The measures come as London hosts the first ever Global Ministerial Mental Health Summit, organized together with the OECD and supported by the World Health Organization (WHO).

Mental health disorders have "dramatically risen" around the world in the last 25 years, according to Dr. Pattel of Harvard University, who presented his findings in The Lancet and described the global mental health situation as "extremely bleak."

The study focused on 1,400 cardiac arrests in kids ranging in age from 2 to 18 years. Most of these cases, 75 percent, happened in private places and 63 percent were not witnessed by other people who might have been able to treat kids with an automated external defibrillator (AED).

Overall, bystanders used AEDs before ambulances arrived in just 28 percent of cases. The vast majority of these incidents involved first responders like lifeguards or police officers who deployed AEDs before ambulances reached the scene.

Not surprisingly, children who went into cardiac arrest in a public location were almost twice as likely to have a bystander use a defibrillator compared with kids whose arrest happened in homes or other private locations, researchers report in Pediatrics.

Older children were also 50 percent more likely than younger kids to have bystander use an AED. Patients who got defibrillator treatment before ambulances arrived were 13 years old on average, compared with an average age of 10 among kids who didn’t get this treatment.

Just 19 percent of the children in the study survived to go home from the hospital.

Still, it’s unclear from the paper how survival differed for kids shocked before ambulances arrived compared with children who got shocked afterwards, said Dr. Myron Weisfeldt, a researcher at Johns Hopkins University in Baltimore who wasn’t involved in the study.


Source: https://www.reuters.com/article/us-health-cardiacarrest-kids/bystander-defibrillator-use-more-likely-for-older-kids-idUSKCN1M72SC
Drug Diversion: 
The 2018 Crisis Update & Our Future

September 20, 2018
Webinar Month 118

For resource downloads go to:
www.safetyleaders.org
Drug Diversion: The 2018 Crisis Update & Our Future

Kimberly New, JD, BSN, RN
Diversion Specialists, LLC
Knoxville, TN

TMIT High Performer Webinar
September 20, 2018
Anonymous Survey Questions

I am interested in ADDITIONAL INFORMATION on:
Drug Diversion Including Speakers from Hospital Programs

88% Agreed and 66% Strongly or Very Strongly Agreed, and 37% Very Strongly Agreed

Source: TMIT High Performer Webinar Series; Drug Diversion: The 2018 Crisis Update & Our Future – September 20, 2018
Specific Drug Diversion Issues I would like covered include:

- Anesthesia provider monitoring
- Any and all of it
- Auditing of records
- Best practice in data reporting to oversight committee
- Best practices in using tools like RX auditor, auditing tools for non-pain associated controlled substances (like stimulants)
- Better methods to educate staff for awareness
- Characteristics to look for with drug diversion
- Commonly missed diversion tactics
- Conducting the interview- see NJ drug diversion meeting from June sponsored by NJDOH
- Conflict of interest
- Data on how often this actually happens by state, etc.
- Detecting diversion
- Diversion in the pharmacy department
- Diversion program details who, what when how.
- Drug screen panels
- Effective auditing resources, processes
- Falsifying patient administration to divert.
- Gold standard for a drug diversion hospital program
- Handling improper drug wasting
- Helping staff feel empowered to report suspicions
- How do we catch the culprits using the EHR
- How FFS Medicare folks are applicable to this topic
- How to convince administration to invest in diversion program
- How to identify a drug diverter
- How to influence anesthesia into this process? What should be the practice for Propofol?
- How to start a program from scratch
- I would like to hear testimonial from a healthcare worker who has successfully completed a BRN diversion program
- Identifying bad practice vs diversion
- IV medication safety storage for narcotics on inpatient units - how do you mitigate risk for diversion.

Source: TMIT High Performer Webinar Series; Drug Diversion: The 2018 Crisis Update & Our Future – September 20, 2018
Specific Drug Diversion Issues I would like covered include:

- Is there a federal or interstate communication available for offenders. Of drug diversions? We have seen the professional boards who give slow reaction to providing discipline on licenses and in the meantime, the diverter is jumping state lines.
- Law review
- Monitoring practices
- MRO negative due to RX for same drug they diverted
- My situation is that I cover all system entities that are not acute care, LTC, homecare/ hospice, physician practices and a social service agency which can all easily have this as an issue.
- New methods of diversion discovered. What to look for to catch them.
- Nurse manager daily and weekly responsibility and the amount of time that it takes
- Opioids
- Opioids
- OR setting - anesthesia (fentanyl)
- Out patient environment
- Patient sources of diversion
- Possible techniques used by staff to divert medications.
- Programs for nursing homes
- Proper response to detection
- Setting up a planned program
- Should policy state extract time to waste.
- Staff signing for discarding without actually seeing disposal.
- State health department role
- Streamlining auditing processes, artificial intelligence software
- The way of diversion that others have encountered
- Types of audits used in long term care
- Ways diversion happens; stories
- Ways to audit anesthesia providers
- What are indicators of drug diversions
- What is the best process for auditing controls in automated dispensing machines?
- What prompts an investigation? Does the hospital have to initiate an investigation?
The health of our medical literature, which is intimately linked to the health of our patients, is facing a serious threat. Medical journals disseminate evolving knowledge, providing a compass for guiding evidence-based clinical practice. But while practitioners around the world use the medical literature to inform high-stakes decisions, the literature we rely on is in trouble. Retraction rates are on the rise, irreproducible research is far too common, and a flood of inconsequential publications distracts attention from higher-value scholarship. Academic medicine must identify the root causes of our literature’s decline and quickly implement effective solutions.

Influential leaders have already sounded this alarm. Speaking to the integrity of the medical literature, Dr. Richard Horton, editor-in-chief of The Lancet, recognized what a growing number of academics are beginning to fear: “The case against science is straightforward: much of the scientific literature, perhaps half, may simply be untrue.”

Echoing this sentiment, Dr. Marcia Angell, former editor-in-chief of the New England Journal of Medicine, wrote, “It is simply no longer possible to believe much of the clinical research that is published.”

Grieneisen and Zhang found that the rate of retractions in academic journals increased 11-fold from 2001 to 2010, after adjusting for publication volume and repeat offenders. In a separate study evaluating over 2,000 retracted articles from biomedical and life sciences journals, Fang et al found that scientific misconduct accounted for two out of every three retractions.

In The News …

August 20, 2018

Unfortunately, threats to the integrity of U.S. biomedical research exist. NIH is aware that some foreign entities have mounted systematic programs to influence NIH researchers and peer reviewers and to take advantage of the long tradition of trust, fairness, and excellence of NIH supported research activities. This kind of inappropriate influence is not limited to biomedical research; it has been a significant issue for defense and energy research for some time. Three areas of concern have emerged:

1. Diversion of intellectual property (IP) in grant applications or produced by NIH supported biomedical research to other entities, including other countries;

2. Sharing of confidential information on grant applications by NIH peer reviewers with others, including foreign entities, or otherwise attempting to influence funding decisions; and

3. Failure by some researchers working at NIH-funded institutions in the U.S. to disclose substantial resources from other organizations, including foreign governments, which threatens to distort decisions about the appropriate use of NIH funds.

“We recently reminded the community that applicants and awardees must disclose all forms of other support and financial interests, including support coming from foreign governments or other foreign entities.”

“We also expect and encourage your institution to notify us immediately upon identifying new information that affects your institution’s applications or awards. Lastly, we encourage you to reach out to an FBI field office to schedule a briefing on this matter.”
Top Cancer Researcher Fails to Disclose Corporate Financial Ties in Major Research Journals

Baselga’s extensive corporate relationships and his frequent failure to disclose them illustrate how permeable the boundaries remain between academic research and industry, and how weakly reporting requirements are enforced by the medical journals and professional societies charged with policing them.

Many journals and professional societies do not check conflicts and simply require authors to correct the record.

The guidelines enacted by most major medical journals and professional societies ask authors and presenters to list recent financial relationships that could pose a conflict.

But much of this reporting still relies on the honor system. A study in August in the journal JAMA Oncology found that one-third of authors in a sample of cancer trials did not report all payments from the studies’ sponsors.

The American Association for Cancer Research said it had begun an “extensive review” of the disclosure forms submitted by Baselga.

It said that it had never barred an author from publishing, and that “such an action would be necessary only in cases of egregious, consistent violations of the rules.”

Among the most prominent relationships that Baselga has often failed to disclose is with the Swiss pharmaceutical giant Roche and its United States subsidiary Genentech.

Source: https://www.propublica.org/article/doctor-jose-baselga-cancer-researcher-corporate-financial-ties
Some of Dr. José Baselga’s known relationships with health care companies. He has failed to disclose any industry ties in dozens of research articles since 2013.

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<tr>
<th>Board of Directors</th>
<th>Scientific or Clinical Advisory Board</th>
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<td>Aura Biosciences* (cancer startup)</td>
<td>ApoGen Biotechnologies (cancer startup)</td>
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<td>Bristol-Myers Squibb</td>
<td>Aura Biosciences (cancer startup)</td>
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<td>Foghorn Therapeutics (cancer startup)</td>
<td>Grail (cancer testing startup)</td>
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<td>Grail* (cancer testing startup)</td>
<td>Juno Therapeutics*</td>
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<td>Infinity Pharmaceuticals* (cancer startup)</td>
<td>Northern Biologics (cancer startup)</td>
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<tr>
<td>Varian Medical Systems (radiation equipment)</td>
<td>Paige.AI (pathology startup)</td>
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<td>Tango Therapeutics (cancer startup)</td>
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<td>Roche/Genentech*</td>
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José Baselga has resigned from his position as physician-in-chief and chief medical officer of Memorial Sloan Kettering Cancer Center less than a week after The New York Times and ProPublica reported that he had failed to disclose his conflicts of interest in scientific and medical journals and at professional meetings. After the conflicts—involving millions of dollars—were enumerated in an article published Sept. 9, Baselga attempted a mea culpa strategy while MSK pointed out that disclosure rules are vague and inconsistent.
In The News …

Conflict of Interest Timeline
2018 Memorial Sloan Kettering Case

Dr. Baselga top cancer researcher fails to disclose corporate financial ties (Roche and Bristol-Myers Squibb) in major research journals (NEJM and Lancet).

Dr. Jose Baselga top official at Memorial Sloan Kettering resigns after failing to disclose industry ties.

Dr. Jose Baselga resigned from the board of drug maker Bristol-Meyers Squibb.

NYT reports insiders at Memorial Sloan Kettering are founders of artificial intelligence start up Paige.AI.

Chairman of the board of Memorial Sloan Kettering Cancer Center (Mr. Warner) bluntly disparaged Dr. Baselga in a NY Times article.

Top Researchers including CEO file at least 7 corrections in medical journals divulging conflicts of interest not previously disclosed.
Top researchers at Memorial Sloan Kettering Cancer Center have filed at least seven corrections with medical journals recently, divulging financial relationships with health care companies that they did not previously disclose.

The hospital’s chief executive, Dr. Craig B. Thompson, disclosed his relationship with companies including the drug maker Merck, and Dr. Jedd Wolchok, a noted pioneer in cancer immunotherapy, listed his affiliations with 31 companies.
Two years ago, Dr. Ricardo Quarrie, a cardiothoracic fellow at Yale New Haven Hospital, was publicly accused of lying to a patient to cover up a surgical mistake.

The stories went viral and the ramifications were swift and severe: Quarrie says he became a "pariah" and potential employers have shunned him. Accused of such a heinous act, his promising future in a prestigious field disappeared.

Now, the lawyer who accused Quarrie has recanted.

"The statements attributed to Dr. Quarrie were made by another health care practitioner at the hospital, or his designee," Faxon wrote. "I hope this letter clarifies any misunderstandings."

Sham Peer Review, Defamation and False Allegations, Prosecutorial Misconduct, and Whistleblower

Definition:
Sham HR Review – An performance review undertaken in bad faith by human resources for some purpose other than the honest review of an employee’s work and that is disguised to look like legitimate performance review.

Tactics
Papering the File
Surprise Assessments
Similar Behaviors to Sham Peer Review Tactics
The Innocence Project, founded in 1992 by Peter Neufeld and Barry Scheck at Cardozo School of Law, exonerates the wrongly convicted through DNA testing and reforms the criminal justice system to prevent future injustice.

The Healthcare Innocence Project builds on the successful model of The Innocence Project. Where it used the new technology of DNA 25 years ago, we will use the new technology of electronic records and the digital DNA in the E.H.R. and administrative records to protect the medical identity of patients and the professional identity of caregivers. Both patients and caregivers may be unjustly treated through intentional or unintentional behaviors of insiders or outsiders of healthcare organizations. They include weaponization of HR, sham peer review, discrediting patients and families after healthcare accidents, or unjust harm through outsider cybersecurity issues.
I am interested in ADDITIONAL INFORMATION on:
CONFLICT OF INTEREST ISSUES RELATED TO SAFETY

52% Agreed and 24% Strongly or Very Strongly Agreed, and 14% Very Strongly Agreed

Source: TMIT High Performer Webinar Series; Drug Diversion: The 2018 Crisis Update & Our Future – September 20, 2018
Specific Conflict of Interest Issues I would like covered include:

- Any related to diversion
- Anything
- Bullying
- Chief compliance officer and other VPs
- Conflicts with entrepreneurial type ventures within a physicians office
- Disclaimers should be automatic
- Industry sponsored education
- Outpatient surgical centers
- Pharmacy and investigation
- Primer on conflict of interest for risk manage
- Receiving food etc., from schools of nursing at a hospital?
- Research

- Self insured facilities
- Staff report of safety issue and need for action to be taken
- Strong declaration
- Unknown
- What constitutes a conflict of interest?
- Workplace violence and prepping colleagues for a simulation event to minimize real fear
Specific Topics regarding ELECTRONIC RECORD and PATIENT SAFETY I would like covered include:

- A roadmap to conducting a drug audit
- Anything
- Care received by patient's from nurses potentially diverting
- Chance of identity theft
- Closing gaps in the timeline of patient care
- Communicating shift to shift hand off
- Communication of work place violence concerns and patient handling issues.
- Copy & paste
- Copy and paste functionality
- Diversion, security, violence in healthcare
- Drop down menus and errors
- Ed violence
- Fall prevention
- Governance of EHR - it's role in clinical decisions
- Highest risk areas
- How do we put tracking systems in our EHRS to find safety problems. What are the most common missed diagnosis issues.
- How to make the record as accurate as possible instead of just automatically answering the questions in the same way.
- Leveraging the medical record to enhance patient safety
- Medication reconciliation how it is best done using an electronic health record
- Patients accessing their records
- Preventing overlays
- Software integration
- Types of errors seen with EHR
- Unapproved abbreviations typed into free text fields and if this has resulted in any patient harms/errors. Our physicians want to do away with ISMP abbreviation recommendations and only use TJC as they do not believe this is an error prone area.
- Vendors do not correct their systems and so many chances for ade/drug interactions, duplications and how these electronic record vendors do not correct these findings. Health literacy of these dc summaries and medication summaries of these systems.
- What is available
- When implementing a new EMR, key items to monitor.
- Why can't they function from clinical needs instead of the ehr dictating clinical practice
- With large system-wide EMR systems, what is a healthcare provider/staff going to be held accountable for reviewing in order to care for a patient? In other words, how far back in a patients medical record history is a provider going to need to review or be accountable for reviewing when you might now have years worth of data you can access.

Source: TMIT High Performer Webinar Series; Drug Diversion: The 2018 Crisis Update & Our Future – September 20, 2018
**Executive Summary**
American Nurses Association
Health Risk Appraisal

**Healthy Work Environment**

90% responded that they are familiar with their workplace's written safety guidelines and policies
80% felt that their employer valued their health and safety
78% felt treated with dignity and respect

68% put their patients' health, safety, and wellness before their own

82% said they are at a "significant level of risk for workplace stress"

**Key Findings: October 2013-October 2016**

Workplace stress was identified as the top work environment health and safety risk
EXECUTIVE SUMMARY
American Nurses Association
Health Risk Appraisal

45% of respondents ranked lifting/repositioning of heavy objects as a significant health and safety risk for nurses

73% had access to safe patient handling and mobility technology

Only 51% used that technology every time they transferred or moved a patient

1/2

About half of the respondents had been bullied in some manner in the workplace

59% of respondents reported that they worked 10 hours or longer daily

51%

reported experiencing musculoskeletal pain at work
### Executive Summary
American Nurses Association
Health Risk Appraisal

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<th>25% had been physically assaulted at work by a patient or patient’s family member; 9% were concerned for their physical safety at work</th>
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<td>56-57% reported often coming in early and/or staying late and working through their breaks to accomplish their work</td>
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<td>33% said they had often been assigned a higher workload than that with which they were comfortable</td>
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<td>93% reported access to sharps safety devices</td>
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<td>86% used these safety devices all the time</td>
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<td>30% were involved in their selection and evaluation</td>
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Dauntless Leaders in Nursing: Impacting Patient Safety

Kathleen Bartholomew, RN, MN

Best-selling Author
Leadership Educator
Friday Harbor, WA

TMIT High Performer Webinar
October 18, 2018
Dauntless Leaders in Nursing: Impacting Patient Safety

Kathleen Bartholomew, RN, MN
kathleenbart@msn.com
"The world as we have created it is a process of our thinking. It cannot be changed without changing our thinking."

Albert Einstein
Objectives

• Acknowledge that building an HRO requires dismantling the hierarchy
• Evaluate the R/T between power and voice
• Explain why nurses must be dauntless
• Identify the major barriers to high reliability
“The first accountability of a leader is to know reality”

Max Dupree
“Alas, culture is not what we say, what we think, what we mean, or even what we intend; it's what we do.”

Jon Burroughs, MD
Why we don’t see reality…

- Human adaptability
- Underestimate context
- Normalization of deviancy
- Distant managers
- Myopic embedding
Changes that are small and incremental are not noticed.
Practice Findings

- Interrupted mid-task 8 times
- Experience 8.4 work failures per shift
- Tasks take an average of 3 minutes each
- Over 160 tasks in an 8 hour shift
- 7-8 items staked at any given time (Tucker, 2006)
- 10 or more waiting to be performed
- Lack of time for reflection, delegation and assessment
IN CASE OF FIRE

EXIT BUILDING BEFORE TWEETING ABOUT IT
32.8% linked DB with adverse events
35.4% linked to medical error
24.7% to compromising patient safety
12.3% to mortality  (Rosenstein, 2011)
Why we don’t see reality

(Culture)…

• Human adaptability
• Normalization of deviancy
• Distant managers
• Myopic embedding
“Our lives begin to end the day we become silent about things that matter”

M. L. King
Why don’t you speak your truth?

• Fear of retaliation
• Fear of hurting the relationship/feelings
• Fear of gossip, scapegoating,
• No time
• Why bother? Nothing will change
• Fear of being isolated from the group

(Bartholomew, 09)
**Overt:**
name-calling, sarcasm, bickering, fault-finding, back-stabbing, criticism, intimidation, gossip, shouting, blaming, put-downs, raising eyebrows, etc.

**Covert:**
unfair assignments, eye-rolling, ignoring, making faces (behind someone’s back), refusal to help, sighing, whining, sarcasm, refusal to work with someone, sabotage, isolation, exclusion, fabrication, etc.
HIERARCHY

• Staff complain to mgr. or each other
• Boss solves problems
• People know their place
• No feedback sought
• Secrecy and blame
• Control as key
• Different rules for different roles
<table>
<thead>
<tr>
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<th>TRIBE</th>
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<td>• Staff complain to mgr or each other</td>
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<td>• Peer evaluations</td>
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<td>• Just Culture – open sharing</td>
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<td>• Control as key</td>
<td>• Relationships as key</td>
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<td>• Different rules for different roles</td>
<td>• 100% of staff held to same standard</td>
</tr>
</tbody>
</table>
Know Reality

• Non-verbal behaviors tolerated
• Hierarchical
• MOST people are great
• Don’t rock the boat
• Poor confrontation skills
• Self silencing
• Status Quo – only human
• That’s the way it’s always been
Key Points

• Culture trumps everything.

• A hierarchical power structure can never protect our patients or support our work.

• True competency and engagement can only happen if self esteem and voice are high, and leaders are resonant and authentic.

• Feedback changes the power structure.
“Leaders bring the future into the present”
BARRIERS

• Culture trumps everything. Know reality.

Status Quo

• A hierarchical power structure can never protect our patients or support our work

Hierarchy

• True competency and engagement can only happen if self esteem and voice are high, and leaders are resonant and authentic

Self-silencing – skill deficit

• Feedback changes the power structure

Fear based culture
**Why do we need dauntlessness?**

1. Because being in a hospital is the 3rd leading cause of death in America
2. Because nursing is rewarding and stressful work – but that stress can be lessened by great teamwork
3. Because the health of our country is trending dangerously downward
4. Because Nursing can preserve humanity
I don’t talk about someone who isn’t present.
I routinely ask my peers for feedback.
I don’t email or text when I am upset with co-workers
I help others when I am caught up with my work.
I hold important conversations in private.
I don’t join into the blame game when something goes wrong.
I don’t tear someone down to lift myself up.
I invite new people to join me for a meal or coffee.
I don’t sigh, roll my eyes or raise my eye-brows. I use words.
What can you do?

1. Ask for Feedback from 2 co-workers
   *What do I do well?*
   *What would you like to see more of?*

2. In rounding, 1:1 ask, “Can anyone take care of your loved one?”
   - If the answer is “NO” ask how many people cannot care for your loved one but do not ask for names
2023
2023

• There are no exceptions to the rules
• High trust – feedback and open sharing of errors
• Process improvements generated by front line
• People are using a common language
• Anyone can take care of your loved one
  No “heads up”
To build an HRO, build trust….

• Correct communication skill deficit
• Flatten the hierarchy
• Establish ONE primary goal
• 100% compliance
• “Chase ZERO”
• Establish feedback as a norm
Metrics: Connect the Dots

1. Can anyone take care of or operate on the person you love the most?
   .................Cognitive Dissonance - Ethical Obligation

2. Can you speak up freely to anyone about anything at all?
   ............... Wishful thinking and Reality
"The world as we have created it is a process of our thinking.

It cannot be changed without changing our thinking."

Albert Einstein
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http://www.bing.com/videos/search?q=brene+brown+ted&FORM=VIRE8#view=detail&mid=95E493CE358180F5527195E493CE358180F55271
Thank you!

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- 206-356-2599
- www.kathleenbartholomew.com
I am interested in ADDITIONAL INFORMATION on:

The Opportunities FOR NURSES IN PATIENT SAFETY

Specific NURSING Issues
I would like covered include:
National Survey Questions

I am interested in A WEBINAR on:

PATIENT SAFETY AND EMERGENCY DEPARTMENT CARE

10
Very Strongly Agree

9
Strongly Agree

8
Agree

7
Neutral

6
Neutral

5
Negative to Neutral

4
Disagree

3
Strongly Disagree

2
Very Strongly Disagree

1

Specific EMERGENCY DEPARTMENT CARE Issues

I would like covered include:
Speakers and Reactors

Kathleen Bartholomew
Unknown
Charles Denham
Voice of Patient and Family

Becky Martins

Founder, Voice4Patients.com
TMIT Patient Advocate Team Member
Warren, ME

TMIT High Performer Webinar
October 18, 2018